World No-Tobacco Day

World Health Organization

ADVISORY KIT 1993

"Health services:
our window to a tobacco-free world"

World No-Tobacco Day

WHO SUPPORT FOR WORLD NO-TOBACCO DAY, 31 MAY 1993

"Health services: our window to a tobacco-free world"

The following information has been compiled to support the celebration of World No-Tobacco Day. It suggests activities to help promote the transmission of the message "Health services: our window to a tobacco-free world". These activities will need to be adapted to the cultural and socio-economic conditions of individual countries and communities and, in particular, to the functions of national health systems and the role of the health personnel. For this reason there is no copyright on the material produced by WHO and, subject to agreement on the design of graphic material, it can be reproduced or modified to bear the specific names of countries, organizations, towns and local transport authorities, and thereby contribute to making 31 May 1993 another successful World No-Tobacco Day. ▮

The advisory kit for World No-Tobacco Day, 31 May 1992, contains the following:

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In addition...

to the present information kit, the World Health Organization intends to produce the following items as background material for the sixth World No-Tobacco Day:

- a press kit, featuring articles, pictures, a sticker and a poster;
- a video (12 minutes) on "Health services: our window to a tobacco-free world";
- radio recordings, to be made by various WHO experts on the subject of tobacco control.

If you are interested in any of the above, please ensure that you submit your order in advance to the WHO focal point for your region which you will find listed on page 23 of this kit. A charge will be made for the provision of the video. ▮

"HEALTH SERVICES: OUR WINDOW TO A TOBACCO-FREE WORLD"

What is the message from the World Health Organization for World No-Tobacco Day 1993 ?

Those who suffer have always looked to health workers not only for relief but also for guidance to help them develop and maintain healthy minds in healthy bodies. In many countries, one of the most glaring violations of this exemplary function is the use of tobacco and the dependence engendered by it.

In 1990, Dr Hiroshi Nakajima, Director-General of the World Health Organization, in his main address to the Seventh World Conference on Smoking and Health, had called on "all health professionals and health workers to stop smoking, as an example to others, and to make the health services tobacco-free. Health service premises are our window to the world. When people look through the windows of hospitals, health centres, medical laboratories, ambulances, doctors' and dentists' surgeries, pharmacies or opticians' offices, let them see no one smoking".

Any buildings or premises used by the health professions should be protected from tobacco sale and consumption. The prestige of the health services and the confidence of the public in them should not be undermined by exposing patients who seek care and reassurance to the risks of passive smoking.

Countries in which the dangers of smoking were first identified, such as Australia, Canada, Norway, the United Kingdom, or the United States of America, reported a decline in the prevalence of smoking among doctors from more than 60% in the 1950s to less than 10% today. What better example could we have! It comes from the very people who have seen their patients die from lung cancer and other respiratory diseases, or cardiovascular diseases, which could have been prevented had these patients not smoked.

But our admiration must be tinged with criticism as we look to those who devote their lives to health for all. All too often a smoky haze still pervades the atmosphere of the health services, and in some countries there are higher rates of smoking among health workers than among the general public; most education campaigns to prevent smoking will come to nothing if doctors and other health professions smoke: it is now crucial for the health professions to face up to this challenge.

WHO is very conscious that health systems cannot continue to advocate no smoking if they do not themselves set the example, and is therefore appealing to the health services and professions on the occasion of World No-Tobacco Day 1993, to set an example, once again, and lead the way towards a healthy society in which the social norm will be to refrain from smoking. ■

World No-Tobacco Day

EVENT PLANNER

How is the message to be conveyed?

The events organized for World No-Tobacco Day lend themselves to media reporting: they can be filmed, discussed in radio interviews, photographed or reported in newspapers and magazines. All the activities – distributing information at the workplace, having main industries and companies observe the Day or even declare their premises tobacco-free, displays of posters or photos – can become media events as long as national and local media (television, radio, newspapers and magazines) are contacted in good time. All gatherings in pubic places or at the workplace can be turned to advantage. The material distributed by WHO should be seen simply as a catalyst, a starting point for local activities whose only limits are the resources and talents of the local organizers. The aim is to inform not only the public but also decision-makers who could help combat smoking, especially along the lines of the year's theme. ■

The following questions may be of use:

1

What is our purpose in organizing this event?

2

How can we gain the participation of the greatest number of people?

3

What media representatives – from the press, radio and television – should we contact right now, to tell them about the activities planned for World No-Tobacco Day?

4

What items should we have made: T-shirts, badges, posters, letters for the use of the organizers?

5

How can leading figures in the community, health personnel, and families help us organize and celebrate World No-Tobacco Day?

6

What celebrities might agree to participate?

7

How could the media help with advance publicity for World No-Tobacco Day?

8

How can the events be organized so as to enable the press to write articles about it or take photographs?

9

How can action be sustained after World No-Tobacco Day in order to create a greater number of tobacco-free health services?

10

How can our work for this year's World No-Tobacco Day help us prepare for 31 May next year?

What is World No-Tobacco Day?

In view of the scientifically proven dangers of tobacco both for smokers and for non-smokers who inhale smoke produced by others, WHO has committed itself to fighting this menace. World No-Tobacco Day, celebrated on 31 May each year, is intended to discourage tobacco users from consuming tobacco and to encourage governments, communities, groups and individuals to become aware of the problem and to take appropriate action. In 1992, the emphasis was given to the place of work: "Tobacco-free workplaces: safer and healthier". In 1993, we will concentrate on the role of health services, including health personnel, and on the need for a dual approach as both example-setter and educator: "Health services: our window to a tobacco-free world". ▮

Why has this theme been chosen for World No-Tobacco Day 1993?

Do as I say but not as I do ... this familiar adage is often cited ironically to describe the attitude of those who make demands on others that they would be reluctant to fulfil themselves. Sadly, this reproach could also be addressed to many doctors and health workers who smoke when they ought to be better placed than others to know the ravages that can be caused by tobacco and to dissuade people from smoking. What is needed to start with is an example ! With the prestige and authority traditionally enjoyed by the medical profession in the eyes of the public, can doctors' advice really carry much weight when they themselves are seen to be smoking? Merely to ask this question implies the answer...
It is clearly important that nurses and all other health professionals, as well as doctors, should set an example by giving up this habit now that the risks have been amply demonstrated. Smoking should also be banned in all health centres, hospitals and dispensaries. Surprising though it may seem, there are only a few hospitals that do not allow smoking, even in the countries that are aware of the dangers of tobacco. Hospital patients as well as the staff have the right to breathe air that is not polluted by tobacco smoke, and hospitals and health centres are both public places and places of work, epitomizing the type of place in which smoking should be banned as a matter of priority. The sixth World No-Tobacco Day on 31 May 1993 will be aiming to focus the attention of all the world's health services and health workers on their role as a "showcase for health" and to highlight their responsibilities towards smokers, passive smokers and non-smokers. ▮

World
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"HEALTH SERVICES: OUR WINDOW TO A TOBACCO-FREE WORLD"

Facts for action

I. Introduction

Tobacco-free health systems comprise four major elements:

- Tobacco-free health premises (for patients, visitors and staff)
- Prohibition of the sale or promotion of tobacco on their premises
- Tobacco-free (non-smoking/non-chewing) health personnel and students
- Health promotion activities for a tobacco-free society, including cessation support services for patients and staff

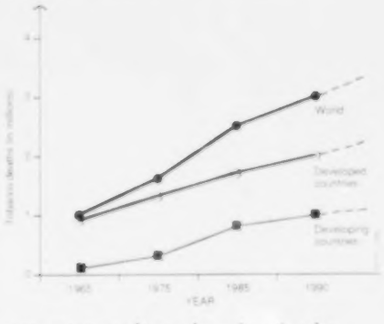
The "raison d'être" of health services and health personnel is to render care and relief to human beings with physical and mental afflictions. This role has progressively been extended to include responsibilities in health education and health promotion. Furthermore, as a result of the prestige attached to their knowledge and capacities, health workers are often taken as role models for healthy living; hence the need to disassociate all elements of the health system from tobacco consumption. However, the present situation is far from being perfect, or even good. Many countries still report a high prevalence of smoking among health personnel, and a continuing need to liberate health premises from tobacco.

Scientific evidence of the risks associated with smoking and passive smoking make it a health policy priority to accelerate international advancement in this field. Featured below are highlights of facts, figures and situations from around the world which call for further action to promote tobacco-free health services, together with examples of how it can be achieved. ■

II. The health burden of tobacco use

Tobacco-related deaths have reached epidemic proportions in many regions of the world and will become a global pandemic unless tobacco-control measures are more widely and more efficiently implemented. Globally, tobacco is estimated to cause at least 3 million deaths a year, about 1 million of which occur in developing countries (Figure 1). However, per capita cigarette consumption in these countries has risen on average by over 70% during the last 25 years and on current trends, WHO estimates that there will be about 7 million deaths a year from tobacco in developing countries within the next two or three decades. In the developed countries, where smoking, particularly among males, has been common for decades, at least 2 million deaths a year (or 20% of all deaths) are attributable to smoking. About three-quarters of these (1.6 million) occur among males although smoking attributable mortality in many countries is now rising at least as fast among women as among men. In the United Kingdom and the United States, the two countries where female smoking first became widespread, deaths from smoking among women are expected to exceed those of males by the beginning of the next decade. Recent evidence has confirmed that the risks of smoking are much higher than previously thought: at least a third, and probably as many as one-half of all smokers will

Figure 1
Global tobacco-related mortality, 1965-1995



eventually be killed by their habit. For males in the developed countries as a whole, WHO estimates that 90-95% of lung cancer deaths, 45-50% of all cancers, 75-80% of chronic obstructive lung disease (primarily chronic bronchitis and emphysema) and 20-25% of cardiovascular disease deaths are due to smoking. For females, the proportions are lower due to their shorter smoking histories but the proportions are rising. For example, three-quarters of all lung cancer deaths in women in developed countries are already attributable to smoking and in the United States and the United Kingdom, this proportion is projected to reach close to 90% by the mid-1990s, similar to what is currently observed for men.

Numerous other **adverse health conditions** including other respiratory diseases, peptic ulcers and pregnancy complications are also attributable to smoking. The adverse effects of smoking on pregnancy outcome range from low birth weight to increased incidence of spontaneous abortions, prematurity, still-births and sudden infant death syndrome. Low birth weight is one of the strongest predictors of infant mortality. Other long-term effects on the child include impaired physical and intellectual development. Tobacco used in smokeless forms, e.g. for chewing and snuff taking, is a major cause of oral cancer in countries, mostly in the Indian subcontinent, where the practice is widespread.

Exposure to **environmental tobacco smoke (passive smoking)** increases the risk of death significantly among non-smokers. Overall, studies have reported a 30-35% increase in the risk of lung cancer for non-smokers due to persistent exposure to environmental tobacco smoke. More importantly, passive smoking has been found to increase the risk of death from coronary heart disease by about 25% in non-smokers. Since coronary heart disease is such a prevalent condition in industrialized countries, the public health impact of this elevated risk in non-smokers is of great importance. Children of parents who smoke compared with those of non-smoking parents have an increased frequency of respiratory diseases, particularly bronchitis and pneumonia, and suffer from a slower rate of growth of lung function, thus increasing their risk of respiratory disease in adult life.

The estimates of disease-specific risks give some indication of the likely **burden on the health system from smoking-induced illnesses.** Overall, smoking is estimated to be the cause of about 30% of all cancer deaths (men and women combined) in the industrialized world, suggesting that a similar proportion of **the costs of caring** for cancer patients in these countries might well arise directly from tobacco use. For vascular diseases, the corresponding proportion is about 15%. Indeed, in the United States, smoking is estimated to account for about one-quarter of total personal health care expenditure for cancers and diseases of the circulatory and respiratory systems. It is unlikely that the costs would be very much different in other populations now suffering the disease burden of years of cumulative exposure to tobacco use.

Smoking materials have also been a primary cause of many forest, residential and industrial fires (with numerous examples occurring in hospitals) and fire-related casualties. Fires present a greater danger in health care facilities than elsewhere due to the number of incapacitated patients who are unable to escape from them.

III. Tobacco-free health premises

The mention of a tobacco-free policy for health premises usually brings to mind hospitals. However, other health premises are often more visible to the community and play an important exemplary role. Such health premises include: medical schools, health centres, maternal and child health clinics, primary health care centres, screening facilities, ambulances, doctors' surgeries, dental clinics and practices, pharmacies, opticians, and rehabilitation facilities.

The term "tobacco-free health premises" implies that tobacco is not used in health care facilities, either by health care workers or by their patients. Nor should tobacco be advertised, promoted or sold in health care facilities (for example, kiosks in hospitals). In some countries, a substantial amount of tobacco products are purchased in pharmacies, some of which may even advertise tobacco products. These practices are completely incompatible with the idea that pharmacies and their staff strive to protect and improve the health of their customers, as well as with the role of health promoter increasingly assumed by pharmacists (see Section V below).

In order to achieve tobacco-free health premises, legislative steps often have to be taken. Already, more than 60 countries have introduced national legislation which restricts smoking in health care facilities. In addition to national legislation, a number of sub-national jurisdictions such as states, provinces, counties, cities, towns, and hospitals, have also adopted regulations to ban smoking in health facilities. In fact, the list of these facilities declared "tobacco-free" is growing in developing as well as in developed countries. Nevertheless, the laws in different countries vary in their comprehensiveness. In some instances smoking is totally prohibited on health care premises, while in others smoking is allowed in designated areas only.

As explained in the advisory kit for World No-Tobacco Day 1992 ("How to create a tobacco-free workplace") such measures have to be implemented with the full participation of employers as has been done through the "smoke-free hospital" movement in many countries, and must be carefully followed up; in particular, employers in tobacco-free health facilities should assist smokers by providing information and by organizing appropriate cessation programmes. Health care institutions should also stress the need for patients to follow smoking cessation support as an integral part of treatment particularly for certain illnesses and diseases such as cardiovascular disease, chronic lung disease, cancer, or diabetes, in much the same way as pharmaceuticals and physiotherapy are prescribed.

For World No-Tobacco Day 1992, WHO underlined that it was the right of all workers to work in a tobacco-free environment; this applies to health workers who require protection from the harmful effects of smoking, whether by their colleagues or their patients. It goes without saying that patients seeking medical attention are seeking to improve and protect their health and should not be exposed to the harmful effects of smoking of other patients or health personnel, particularly those who, through severe disease or disablement, are unable to communicate their objection or avoid the exposure as they queue or wait in medical facilities. ■

SMOKE-FREE KAROLINSKA!

On 1 September 1992, the Karolinska Hospital in Stockholm (Sweden) was declared smoke-free. A booklet published to promote the liberation of this famous institution from tobacco smoke, for staff and visitors, provides some interesting elements:

"'Smoke-free Karolinska' is primarily concerned with occupational environment and with creating a cleaner working environment for all employees.

...

'Smoke-free Karolinska' will result in the following:

- All staff will enjoy a cleaner working environment.
- Health and medical services will gain further credibility.
- The fact that smoking is not allowed will support everyone who wants to quit.
- Young people and the newly employed will not be tempted to start smoking at the hospital.

A smoke-free workplace is a way of making everyone feel better and of increasing awareness of the benefits of a clean occupational environment.

Have consideration for each other!

It is unlikely that someone who has never smoked will understand what it is like to be prohibited from smoking. Consequently, it is important for non-smokers to have understanding for smoking workmates who may get irritated from time to time.

...

Do you need help to quit?

....

Everyone who wants to quit smoking should avail of this opportunity! The occupational health service offers support during working hours. You may wish to join a group or do it individually."

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IV. Health personnel against tobacco use

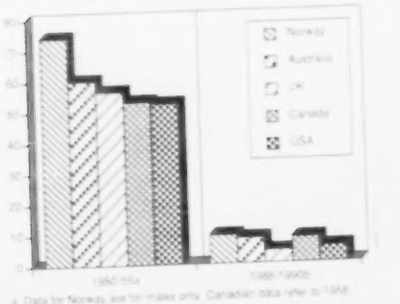
The specialization of the health sector varies from country to country. In some countries the number of categories of health personnel exceed one hundred and represent all strata of society. Nevertheless, whether they be dieticians, environmental specialists, midwives, physicians, or other health workers, they are all united by a common purpose, that is to diminish the suffering of their patients, to improve their state of physical or mental health, and to prevent avoidable deterioration in health. Tobacco use has been recognized as one of the most important avoidable causes of ill health; a fact that should motivate all health personnel to stop smoking and to use their position and working environment to support a tobacco-free society.

a) Prevalence of smoking by health personnel

To act as models in their social environment and to advise their patients on the ill effects of tobacco use, it is important, if not crucial, that health personnel abstain from smoking; the persuasive power of a positive health message conveying the non-use of tobacco will be substantially strengthened if they practice what they preach. Furthermore, health workers will be far more effective, both as advisers and as role models for patients, if they do not smoke themselves. During the past few years, WHO has received information on the smoking behaviour of health staff throughout the world from medical schools, teaching hospitals, federations of health personnel and governments. However, it remains a sparsely surveyed subject and data received are often sketchy. A few points emerge:

- In countries where the risks of tobacco consumption are well known (very often countries where these risks were first studied, in some cases using medical personnel), the prevalence of smoking among physicians has decreased dramatically in the past 30 to 40 years from levels in excess of 50% to less than 10% today (see Figure 2).

Figure 2
Trends in smoking prevalence among physicians, 1950-1990
(United Kingdom, Norway, Canada, Australia, United States)



a. Data for Norway are for males only. Canadian data refer to 1956.
b. Cigarettes only.
Source: National survey reports or estimates based on information available to WHO.

- In a number of developed and developing countries, the rate of smoking by physicians, especially male, appears to be higher than for the general population; these are usually countries at an earlier stage of the "tobacco epidemic" where smoking is most prevalent among the higher socio-economic groups. These physicians may be theoretically aware of the risks of smoking, but have yet to witness the full impact of the tobacco epidemic on their patients, two factors which have led to the dramatic declines in smoking prevalence among physicians elsewhere; in these countries physicians have been among the first to appreciate that dispensing health care and consuming a lethal substance such as tobacco are completely incompatible.

- In countries where women traditionally do not smoke, it is often the case that female health workers also do not smoke. In some of these countries, smoking may be regarded as a sign of female emancipation and more educated young women such as medical doctors often start to smoke. It should be an important part of training to persuade them that it would be professionally irresponsible to do so. The trend towards increasing smoking prevalence among young women could well imply higher female smoking rates among health workers in the future unless professional curricula and greater appreciation of the role model are more effective in promoting tobacco-free health professions.

- Certain health professions, such as midwives and paediatricians, appear to have a systematically low prevalence of tobacco consumption. Unfortunately, others such as surgeons and, in many countries, nurses as well, have a high prevalence of smoking; this may often be due to stress, pointing out that educating health workers on the dangers of tobacco consumption should be complemented with stress control in their working environment.

- An interesting insight to what the future could hold for the health professions is provided by a recent study of medical students in African and Asian countries. It is encouraging that according to this study, both in Africa and Asia, the prevalence of smoking for male medical students is at least somewhat lower than in the general population and in some countries very much lower; prevalence for female students is very low (i.e. below 5%). This pattern is confirmed by similar studies in Middle-Eastern countries.

Training of health personnel in tobacco control

e fact that large numbers of health ofessionals are still smoking derlines the need to provide them th more systematic training to prove their knowledge of tobacco's causal role in many diseases, to equip them with strategies to counter tobacco consumption, and to help them define their own roles in dealing with the tobacco problem. A minimum curriculum on tobacco issues (see box below) should be followed by students of health sciences during their professional training to ensure that all health staff are taught why tobacco control is such an important public health issue and that they are given sufficient information to help control tobacco use.

TOBACCO OR HEALTH
WHAT STUDENTS OF HEALTH SCIENCES SHOULD KNOW

To avoid being an additional burden on the curricula of schools teaching health sciences, knowledge of tobacco should be integrated into the present curricula (as it already is in many medical and nursing schools). The following check-list should enable schools of health sciences to ensure that the subject is adequately covered in its curriculum:

THE BASICS

The harmful components of tobacco smoke which the student should know: Nicotine, tar, potential carcinogens, carbon monoxide, irritants, asphyxiants, role of smoke particles.

Tobacco as an addiction: Physical addiction (nicotine), and social/psychological addiction.

Oral tobacco (in countries where used): Addictive aspects and harmful components.

Why children/people take up smoking: Influence of family, peers, public, commercial promotion, followed by addiction.

TOBACCO-RELATED DISEASES

These should be emphasized in the teaching of the relevant departments and are briefly summarized below:

Major killers: Lung cancer, ischaemic heart disease, chronic obstructive pulmonary diseases (COPD), including emphysema.

Other cancers: Larynx, pharynx, oral cavity, oesophagus, kidney, bladder, pancreas, cervix, and some forms of leukaemia.

Cardiovascular diseases: Ischaemic heart disease (as above), stroke, peripheral vascular disease such as thromboangeitis obliterans, and aneurysm. Cumulative effects with oral contraceptives.

Respiratory diseases: Lung and laryngeal cancers (as above), COPD, predisposing factor for lower respiratory tract infections (all ages), and often exacerbation of asthma.

Alimentary tract: Carcinoma of mouth, pharynx, and oesophagus (as above); peptic ulcers.

Reproductive system: Cervical cancer, reduced fertility, risk to foetus, lower average birthweight, increased perinatal mortality.

Oral tobacco and its effects: Mouth cancer, mouth ulcers, gum disease, tooth loss.

Children and young people: Health (chronic cough and sputum and more acute respiratory illnesses) and social consequences. Passive smoking (see below).

PASSIVE SMOKING

Effects on children: Increased rate of lower respiratory infections in infants, increased eczema/asthma in children, increased cot deaths, decrease in lung function, glue ear.

In adults: Lung cancer, exacerbations in asthmatics, risk of major vascular diseases.

BENEFITS OF QUITTING SMOKING

Benefits of quitting smoking to reduce the risk of acquiring a disease, and benefits of quitting in patients already having a disease.

PREVENTIVE MEASURES

Action by health professionals:

In professional work: Knowing which diseases are smoking related, how to inform patients on the dangers of smoking, and how to advise all patients who smoke to quit (knowledge of counselling methods on smoking cessation).

As an opinion leader: How to encourage and support national anti-smoking organizations. Develop local programmes and campaigns ...

Governmental action: Description of the most effective measures to be taken by governments (resolution WHA39.14), such as price policy, tobacco control in public places and transport, bans on advertising and other socio-economic incentives ...

It is suggested that within health science schools, a coordinator be appointed for this training. An initial survey of students and staff attitudes would enable these schools to better target the training. The coordinator would then produce a written policy covering: smoke-free school premises and hospitality; teaching in relevant departments; examinations; and methods for monitoring progress.

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c) Health personnel and tobacco control: Opportunities and responsibilities

As part of their duties to improve the health of their patients, health personnel have a responsibility to: provide information on the damage to health caused by tobacco use and especially on the reduction of risk when the patient stops; create healthy environments and prevent people from starting a tobacco habit; help tobacco users quit their habit. Last but not least, health personnel should develop and/or support community and institutional programmes for tobacco control, including research components on prevalence and behaviour.

Health personnel are important formal and informal opinion leaders in their local communities, particularly in matters related to health. People trust and value their opinions. Health personnel have an obligation to utilize this trust to achieve the best state of health for the people they serve. If they are members of cultural organizations, religious and other community groups, they should take the opportunity to include the human, medi-

TOBACCO CONTROL: EMPOWERING THE HEALTH PROFESSIONS

All over the world, the health professions often feel unprepared to take action in the tobacco control area. The following is a **programme for a course** that should provide knowledge and motivation. Such a course will have to be adapted to suit individual situations and countries.

PREVALENCE AND CONSUMPTION

History of tobacco use; tobacco consumption in the world with emphasis on the country in which the course is held; tobacco use prevalence in that country.

HEALTH AND ECONOMIC TOLL TAKEN BY TOBACCO

Tobacco constituents; local products; health hazards and environmental tobacco smoke (ETS); epidemiology; morbidity reports (national), estimating mortality/projecting future mortality; economic/health costs.

WHY PEOPLE SMOKE

Physiology and psychology of addiction; children and women; parents and peers; advertising and promotion.

ADVERTISING AND PROMOTION

Purpose of advertising; the product: image and modification; identifying markets/special populations: youth, ethnic minorities, women, blue-collar workers, less education; promotion events: sports and cultural events; free distribution.

TOBACCO ECONOMICS

The tobacco industry; profits/pricing/excise taxes; tobacco industry strategies including lobbying, diversification, etc.

THE ROLE OF HEALTH PROFESSIONALS IN ENDING THE TOBACCO PANDEMIC

- **At the national level:** Policy/legislation – history of local tobacco policy; advertising restrictions/bans; effectiveness of product/advertising warning labels; price policy; restricting sales to minors; regulation of public smoking/clean indoor air; other legislation (fire safety, child protection, disability protection); enforcement of existing laws.
- **In primary health care centres:** Positive health messages, messages counteracting tobacco use and promotion, ancillary personnel involvement; cessation; behavioural treatments: sympathy, group therapy, behaviour modification, focuses on socio-cultural influences; pharmacological treatments.
- **In the classroom (school-based education):** Health professionals' role in schools.
- **In the community:** Mass media – media corporations/advertising agencies; public service campaigns; media advocacy/news clippings; cessation campaigns.

Research: In the areas of smoking-related diseases and smoking prevalence. Community-based research; monitoring of tobacco industry strategies; socio-cultural research; consumer research.

Workplace: Health insurance coverage; voluntary versus legislated smoke-free policies; litigation against employers; employee incentive programmes; cessation services.

Other community action: Coalition building/networking; proactive, multi-level strategies, etc.

cal, social, and economic costs of tobacco use in the list of priorities for these organizations.

Many health personnel are politicians at the local, regional, national or international level. In their political work they should strive for the creation of health-enhancing social and physical surroundings which enable individuals to maintain good health and well-being, such as economic and legislative measures restricting the use and advertising of tobacco products and their proper implementation.

In this critical mass of individuals, some are unfortunately tobacco users, as may be some members of their families or friends, who, if they were to quit their tobacco habit, would represent a significant positive contribution to public health overall.

Yet while health personnel may be motivated to counsel on tobacco issues, some still hesitate to advise their patients on tobacco issues, either because they believe that their training has not adequately prepared them for this type of counselling or that patients are not interested enough to listen and may even change practitioner; an ethical issue that has not been sufficiently emphasized. To remedy this situation, courses should be set up to provide training on specific strategies which can be implemented in clinics, classrooms, and the community (see box page 12). Such training should be basic for primary health care workers. In addition, simple methods for conversing with patients should be widely disseminated which should facilitate smoking cessation advice (see also Section V). Finally, more should be done to convince doctors that it is part of their duty to advise patients on tobacco or health issues.

Health staff often claim not to have enough time to allow a few minutes for this subject, which is strengthened by the fact that, in most countries, health staff do not get paid for health promotion, such as advice on smoking cessation. This situation should be studied carefully by all governments.

d) Health personnel and tobacco prevention strategies

As mentioned before, the first opportunity for health personnel to educate the community is the example they set. The responsibility and potential of health personnel in tobacco control goes far beyond the important but rather passive portrayal of a good tobacco-free model. Health care workers have a responsibility to actively seek out the causes of ill health and implement appropriate preventive strategies. For most categories of health personnel it is easy to find in their specific field of interest, an opportunity to intervene (see box below).

As an example, the dental hygienist who spends 70% of her/his time in primary prevention services is already used to giving advice; a midwife's primary interest is to the health of the foetus and mother and hence to support pregnant women in their attempt to quit smoking; a primary health care worker may be concerned with the future health of school-children in the community because cigarettes are available to them by way of vending machines. What is important to underline is that almost every category of health care personnel, one way or the other, has first-hand experience of the health consequences of tobacco use. This may vary from a dental

CLINICAL OPPORTUNITIES TO TALK ABOUT SMOKING WITH PATIENTS

SYMPTOMS

- Cough
- Shortness of breath

TESTS

- Electrocardiography
- Pulmonary function tests
- Blood pressure measurements
- Auscultation of heart and lungs
- Blood analysis
- Pregnancy tests

DIAGNOSIS OF DISEASE AND RISK FACTORS IN PATIENTS

- Heart and peripheral vascular diseases
- Hypertension
- Emphysema
- Bronchitis
- Asthma
- Diabetes mellitus
- Peptic ulcer
- Allergy

PRESCRIPTION AND ADVICE

- Drug/tobacco smoke interactions
- Pharmacologic aids to smoking cessation
- Dietary and nutritional advice
- Rehabilitation

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PHARMACISTS HELP SMOKERS TO QUIT

"Pharmacists helping smokers to quit" is a new joint concept created by the World Health Organization's Regional Office for Europe and the Danish Pharmaceutical Association. The accessibility and skilled staff of the community of 304 "public friendly" pharmacies in Denmark (150 000 consumer contacts a day) makes them well suited to participating in quit-smoking activities, not to mention their wealth of valuable experience in advising on health matters.

In 1991, the project included the following:

- creating training courses and course material for pharmacists;
- preparing and producing written information material targeted at the general public, mass media, group members, and health care professionals;
- enlisting 20 community pharmacies as pilot project participants;
- conducting a two-day training course for pharmacists;
- launching the campaign;
- creating diaries and questionnaires to evaluate the project.

The first four of the activities listed above were undertaken by the Danish College of Pharmacy Practice, the fifth one by the Danish Pharmaceutical Association in collaboration with the local pharmacies. Media interest in all the activities was very high from the beginning. The programme was so popular that it proved necessary to establish a waiting list. An evaluation will be carried out by a sociologist from the Danish Royal School of Pharmacy.

Health personnel against tobacco use

auxiliary observing tobacco-related staining on the teeth of her/his patients, to a radiologist diagnosing lung cancer. In recent years, there has been increased focus on the role of such health care workers as psychologists, dentists, dental auxiliaries, midwives, and pharmacists (See box above).

The awareness of tobacco issues by health care workers may vary from just mentioning to their patients that smoking cessation will contribute to their general state of good health, to routine offers of advice and written material on quitting the tobacco habit. More formal assistance may include the delivery of cessation programmes in small groups, or on a one-to-one basis in a clinical setting. It is important to note that even less intensive interventions may have an important impact on public health. Trials in the clinical setting of physicians usually show that advice or counselling alone often results in 5 to 10 % quit rates, while more resource demanding interventions often result in a quitting rate of 20-25 % (see box page 15). In many countries governmental and non-governmental organizations have produced specific materials which may be of great benefit to health care workers who want to help their patients to stop using tobacco (*see also Section V below*).

Even though the clinical approach in terms of motivating and helping people to stop using tobacco on an individual basis, is a task of utmost importance for health personnel, the responsibility of health care workers in tobacco control includes **a much more comprehensive preventive strategy**. Health care workers should initiate or facilitate tobacco preventive activities in workplaces and schools. They should organize or support community mobilization

which may enforce social action in the tobacco control field. They should lobby for resources to be allocated to health education activities, and for restrictive measures on tobacco use.

Health care workers should strive to bring about **public awareness and knowledge on tobacco**, and to put tobacco-or-health issues on the agenda of the mass media. This is important because of its effect on the public, but more importantly because tobacco-or-health issues will become a concern for decision makers and politicians. Hence mass media attention may strengthen public support for and facilitate political activity in favour of tobacco prevention approaches directed towards the social environment (for example, legislative or economic measures known to be effective in tobacco prevention). ■

HELP YOUR PATIENTS TO STOP USING TOBACCO

STEPS FOR HEALTH PERSONNEL INTERVENTION

All health workers should be convinced that they can make the difference, here are some tips to start today.

■ **Ask all patients if they smoke**
- Congratulate smokers who have quit.
- Document patients' smoking or non-smoking status in your notes or other forms.

■ **Advise all smokers to quit**
- In the presence of the patient, review some of the benefits of smoking cessation you feel would be meaningful.
- Give a firm, simple no-smoking message such as: "I am concerned about your smoking. I must strongly recommend that you quit".
- Repeat your recommendation when smokers give excuses for not quitting. Never argue about the excuses or accept them.

■ **Prepare smokers to quit**
- Ask the patient to set a target quit date within the next one to four weeks. Ask patients who are not ready to quit to think seriously within the next week about the reasons for quitting.
- Have the patient write down his/her quit date.
- Mention that they should: (a) do something else instead of smoking, (b) avoid tempting situations, and (c) stick with their effort to stop smoking.
- Tell patients they will experience withdrawal symptoms for about 2-4 weeks after quitting.
- Offer information on local smoking cessation programmes.
- Tell all patients you are very interested in hearing how they do.

■ **Follow-up: Let your patients know you care**
- Talk with all patients briefly about their smoking the next time you see them.
- Work with health professionals in other settings to stay in contact with patients and reinforce no-smoking messages.

World No-Tobacco Day

V. Health profession organizations in tobacco control

The international tobacco control movement has been characterized by the active involvement of non-governmental organizations, which have proved to be essential instigators. The health system, in terms of health premises and health personnel, has fostered the development of a number of these national and international non-governmental organizations, such as hospital federations, medical societies or newly created bodies that concentrate on the tobacco issue as a risk factor (for example, the non-governmental organization Council on Tobacco or Health, in Japan).

These federations, societies and organizations promote the participation of the health system in tobacco control by: transmitting specific information rapidly and systematically, using media such as newsletters and television; encouraging and supporting action by their members; propagating models and examples from countries which have been successful, in the hope that other more hesitant countries may be inspired; setting general policies for individual professions; and publishing guidance on how to put tobacco control theory into practice, i.e. guides for oral health teams, community nurses and other health workers, manuals for physicians, and guidelines for pharmacists (see also Section IV). Most importantly, these professional organizations often represent a critical mass which is capable of exerting pressure at the political level for the adoption of tobacco control legislation and for putting the tobacco or health issues on the agenda of political and scientific bodies.

PROFESSIONAL ORGANIZATIONS AND TOBACCO CONTROL ...

. . . INTERNATIONAL COUNCIL OF NURSES POSITION STATEMENT, APPROVED IN 1989

"The "Code for Nurses" adopted by the **International Council of Nurses** states that two of the fundamental responsibilities of the nurse are "to promote health and to prevent illness", and that "the nurse shares with other citizens the responsibility for initiating and supporting action to meet the health and social needs of the public". Smoking is regarded as one of the world's most preventable health problems.

.....

Although the health consequences of tobacco are now well known, measures to deal with them are so far woefully inadequate. Therefore, the International Council of Nurses and its member associations make a commitment to develop methods to reduce and eliminate smoking among nurses and to prevent the initiation of the smoking habit among student nurses.

Member nurses' associations are to bring to the attention of their governments the negative effects of tobacco on health; and encourage their governments to reduce, discourage and eradicate the use of tobacco.

ICN member associations should also commit themselves to encourage their governments to develop policies that ban tobacco advertising and promotion, require prominent and significant tobacco warnings on all tobacco products, provide public education campaigns aimed at eliminating tobacco use and provide incentives to tobacco farmers to make the transition from tobacco to alternative crops."

PROFESSIONAL ORGANIZATIONS AND TOBACCO CONTROL ...

... **EUROPEAN CHARTER FOR HEALTH PROFESSIONALS**, proposed by the European Medical Association Smoking or Health (EMASH) (1991)

"AS A DOCTOR OR HEALTH PROFESSIONAL

I. I AM AWARE OF THE **DAMAGING EFFECT** OF TOBACCO:
- for the smoker
- for those who live with smokers
- for society in general

II. I KNOW THAT TOBACCO IS A **DRUG** WHICH ENTAILS **DEPENDENCE** BOTH **PSYCHOLOGICAL** AND **PHARMACOLOGICAL**

III. I AM READY TO **HELP SMOKERS** WHO WISH TO STOP:
- to encourage them to break the habit
- to offer them suitable treatment
- to help them psychologically during the difficult period of giving up smoking

IV. I WANT TO **DISCOURAGE SMOKING** AMONGST MY PATIENTS:
- by stopping smoking myself and thus presenting a model of the non-smoker
- by not permitting smoking in the waiting room
- by strongly advising non-smoking for my patients and their families
- by taking part in health education particularly with young people
- by promoting non-smoking in my social contacts

V. I REALIZE THAT I HAVE A GREAT **RESPONSIBILITY** NOT ONLY TO PATIENTS BUT ALSO TO THE **PUBLIC IN GENERAL**

I AM URGING THE GOVERNMENT TO UNDERTAKE THE **APPROPRIATE PREVENTIVE MEASURES**

■ ■ ■

WE, **EUROPEAN DOCTORS AND HEALTH PROFESSIONALS** ARE FIRMLY RESOLVED TO UPHOLD THE COMMITMENTS OF THIS CHARTER AND TO UNITE IN ORDER TO REDUCE SMOKING WHICH IS THE SINGLE LARGEST PREVENTABLE FACTOR IN PREMATURE DEATH, DISABILITY AND DISEASE."

To better exploit the various strategies for health promotion available and to assure more cost-effective action, a number of coalitions and networks have been established on a regional basis such as the European Medical Association Smoking or Health (EMASH) founded in 1991, or on an international basis such as DOC (Doctors Ought to Care) which was founded in 1977 to encourage health professionals to become active in counteracting tobacco use and promotion, and now includes more than 150 chapters in 27 countries. World No-Tobacco Day 1993 should also be used to promote and strengthen such coalitions. ■

World No-Tobacco Day

VI. Conclusion

Health care workers have responsibilities and opportunities to initiate the implementation of tobacco control measures at the individual level, in social groups, in the local community, on health premises, and society in general. Health education and the example provided by all categories of health care worker will thus be an important aspect of their daily work with patients and clients, and will play a key role in triggering the implementation of a more comprehensive health promotion strategy to prevent people from using tobacco.

As part of their general policy against tobacco use, governments should also assume their health and social responsibilities and take measures, legislative whenever necessary, promoting and ensuring appropriate training of health personnel in tobacco control and adequate protection of staff and patients in health facilities. They should implement economic strategies to involve health personnel in tobacco prevention and health promotion.

The potential public health impact of concerted action by health personnel and the example set by them in the health system cannot be equalled. Their interventions have proven particularly effective, not only because of their role model effect but also because the frequency with which smokers are seen by health care personnel and the particular susceptibility of patients, as opposed to people in non-medical situations to anti-tobacco messages. It is crucial that the health systems accept their responsibility in tobacco control, otherwise they may witness tobacco consumption undoing much of the progress they have strived to achieve. ▮

In the production of this fact sheet, the primary sources of information have been:

World Health Organization – information emanating from the Tobacco or Health programme, the Oral Health programme, and the Division of Development of Human Resources for Health; documentation from the International Union Against Tuberculosis and Lung Disease (IUATLD); the Department of Health and Human Services, National Institutes of Health (United States); from numerous nongovernmental organizations involved in health services and health personnel; and communications from Sir John Crofton, Dr Ron Davis, Dr Alan Blum, and Dr Eric Solberg.

WORLD NO-TOBACCO DAY: WHAT ARE WE ACHIEVING?

31 May 1992: "Tobacco-free workplaces: safer and healthier

Reports received each year at WHO headquarters reflect a sense of efficacy in the efforts made to celebrate World No-Tobacco Day, and confirm that the occasion constitutes an important part of tobacco control promotion, that it is a prime instrument for public information, and that in some countries, has led to decrease in the number of smokers.
The theme chosen for World No-Tobacco Day 1992 was particularly easy to celebrate at the local level and is likely to have had a great practical impact in generating many tobacco-free workplaces and in giving individual workers the incentive to improve their working conditions by creating tobacco-free workplaces.

The material:

Information received indicates that *the material produced by WHO for World No-Tobacco Day 1992* was extensively used. Information issued for the Day can be found in the magazines, newspapers and various leaflets and pamphlets submitted to WHO by individual countries. As in previous years, WHO graphic material was adapted to suit specific situations and requirements. ▮

The celebration ... in countries

Only a few days after the celebration of World No-Tobacco Day 1992, WHO began to receive reports and press clippings detailing **the celebration of the Day all over the world** and indicating the amount of media coverage the celebration had commanded. These reports highlight the diversity of the celebrations in different countries but due to the advance production of this advisory kit we can only provide a few examples from different countries. Nonetheless, it is hoped that they will assist countries in the planning of celebrations for World No-Tobacco Day 1993.

It is interesting to see the influence of the theme of World No-Tobacco Day 1992 on the methods employed to celebrate the occasion. In a large number of countries with varying socio-economic settings, employers and employees organized symposiums, seminars and conferences to present and discuss the scientific, organizational and managerial issues involved in the issue of tobacco-free workplaces. It presented an opportunity for many countries, and diverse professions in these countries, to realize that the silent majority of non-smokers should be acknowledged and their right to a tobacco-free working environment recognized through appropriate regulations. For example:

- In Togo, a nationwide broadcast appealed to all workers to refrain from smoking at the workplace.
- In Chile, the Ministry of Health used the occasion of World No-Tobacco Day 1992 to launch a

campaign promoting the active use of legislative measures against tobacco use.

- In Nepal, His Majesty's Government declared government and semi-government offices, public places, public transport, industries and factories, as tobacco-free areas. This declaration also included ministries, government controlled corporations, institutions, hospitals, health centres, etc.
- In Norway, hotels and restaurants in the vicinity of the city of Kardemomme, the world's only declared tobacco-free city, agreed to prohibit smoking on their premises for the duration of World No-Tobacco Day 1992, while several local companies arranged quit smoking competitions.
- In the Islamic Republic of Iran, information material produced by WHO was widely distributed and to increase pubic awareness on the issue of tobacco or health, a seminar was sponsored by the Under-Secretary of Health, governmental and nongovernmental organizations, and the mass media.
- In Japan, Dr Hiroshi Nakajima, Director-General of WHO awarded a Tobacco or Health medal to the Tokyo Metropolitan Government for its decision to declare the new Tokyo municipal hall tobacco-free. In addition, a symposium on tobacco-free workplaces was organized by the Ministry of Health and Welfare, the WHO Collaborating Centre for Research on Smoking and Health, and the NGO Council on Tobacco or Health, an alliance of major Japanese nongovernmental organizations who have consolidated their efforts for maximum impact in the fight against the use of tobacco. ▮

... in WHO and the UN system

While the celebration in individual countries is the main purpose of World No-Tobacco Day, mention must also be given to **WHO headquarters and regional offices** in which World No-Tobacco Day 1992 was also celebrated. This celebration included the awarding of Tobacco or Health medals to individuals and institutions within the health field, who were selected for continuing commitment to research and/or health promotion activities at national and international levels and to individuals and institutions outside of the health field cited for achievement worthy of international recognition in promoting the concept of tobacco-free societies.

As in previous years, all UN agencies, and particularly the Vienna International Centre (VIC), staged celebrations of World No-Tobacco Day. The Food and Agriculture Organization of the United Nations (FAO), in Rome, produced its own poster which was widely displayed. Furthermore, a number of agencies of the UN system used the theme of the Day to reinforce and extend their regulations regarding anti-smoking policies at the workplace.

* * *

Finally, the Day was successfully celebrated thanks to the active involvement of a large number of nongovernmental organizations who, once again, have proved to be essential and dynamic instigators of activities for World No-Tobacco Day. ▮

WHAT IS THE IMPACT OF THE WORLD NO-TOBACCO DAY IN YOUR COUNTRY?

WHO had always actively encouraged the evaluation of the impact of the celebration of World No-Tobacco Day in individual countries. As explained in the advisory kits of previous years, such an evaluation may take many forms and may be structured on an individual, municipal, provincial or national basis. This year, it has been decided to present, in more detail, examples of two types of evaluation carried out in different WHO regions and from two different angles in order to show that it can be accomplished and to encourage, within all WHO Member States, a development of appropriate evaluation methodologies.

Is World No-Tobacco Day discouraging tobacco use?

One of the purposes of World No-Tobacco Day is to provide an opportunity for all those who smoke to cease for at least twenty-four hours. Consequently, it is interesting to see how the behavioural effects of World No-Tobacco Day, in terms of the number of smokers who stop smoking on World No-Tobacco Day, can be measured. In 1988 and 1990, interview surveys of representative samples of Norwegian adults were carried out two weeks after World No-Tobacco Day. The sample was drawn (two-stage cluster procedure) and data collected by a commercial poll organization. During the interview, information on the respondents awareness of World No-Tobacco Day, and changes in respondents smoking behaviour on the Day and the following two weeks, were collected.

The 1988 results showed that 96% of the respondents had been aware of World No-Tobacco Day. Five percent of the daily smokers reported having refrained from smoking on the Day, while 18% claimed to have reduced their smoking. Two weeks after World No-Tobacco Day, 2 % of the previous daily smokers still did not smoke, while 9% still reported to have reduced their smoking. Converted into population figures, approximately 240 000 regular smokers did not smoke on the Day, while a similar number reduced their smoking. Based on official more in-depth smoking prevalence data, this implies that the number of quitters on World No-Tobacco Day was 45 times that of any ordinary day among daily smokers, and 200 times as high among occasional smokers.

The 1990 results showed that 87% of the respondents had been aware of the celebration of World No-Tobacco Day. Two percent of the daily smokers did not smoke on World No-Tobacco Day, while 7% of the daily smokers claimed to have reduced their smoking for the Day. These proportions were reduced to 1% and 4%, respectively, two weeks later, which means that approximately 30 000 individuals continued to refrain from smoking or smoke less compared to before World No-Tobacco Day.

Is World No-Tobacco Day cost beneficial?

Every year WHO, as coordinator of World No-Tobacco Day, produces and distributes large quantities of documents and materials to facilitate the celebration of the Day in Member States. Many governments and nongovernmental organizations adapt this material or produce their own to suit their individual requirements. In each WHO region and Member State, and at the regional and local levels, various activities are organized by health authorities, schools, nongovernmental organizations, etc. Alerted by the material distributed or by the originality of the events staged at the national, regional, and local levels, there is extensive mass media coverage of tobacco or health issues before, during and after World No-Tobacco Day. The number of press clippings on the celebration of the event received in WHO from all over the world, highlights the fact that no other anti-tobacco campaign could afford the print space or broadcast time sufficient to achieve the results seen in previous years.

Certain procedures can be used to approximate, within each country, the cost of such media time and space. The American Cancer Society has used standard advertising measures to evaluate the annual Great American Smokeout (GAS), the forerunner of World No-Tobacco Day. A Gallup Poll showed that 83%

of all Americans were aware of the 1991 Smokeout. The poll also showed that more than 35% of all smokers participated, that 7 million of them continued to abstain from smoking for 24 hours, and that nearly 12% of the nation's smokers were still not smoking one to three days later.

This success is greatly due to the amount of free media attention the GAS commands before, during and after the Day itself. To reach the numbers of people represented by the Gallup Poll figures, a conservative estimate suggests that, at a minimum, a four-week advertising campaign would be required and advertisers would have paid out a grand total of more than US $ 16 million for the four-week long campaign.
Similar calculations could be made in other countries for different forms of media, using the appropriate local factors, i.e. the number of television households, the cost of advertising, and the media circulation.

And now?

It is hoped that these practical examples may encourage others to evaluate the impact of World No-Tobacco Day in their own country. Such evaluation studies may adopt many forms, depending on the specific interest and available resources of the researchers: on national or local samples; collecting data by means of telephone, questionnaires or personal interviews; utilizing different designs; studying short-term or long-term effects.

They should address smoking cessation, media utilization, community mobilization and, of course, the precipitation of governmental action. Has World No-Tobacco Day created sufficient pressure to warrant the enactment of a law, bylaw, or regulation furthering the cause of tobacco-free societies? Has your government selected World No-Tobacco Day to improve the official policy or programme addressing tobacco or health? Has the amount of money allocated to the implementation of this policy/programme been increased? Has the enforcement of the anti-tobacco measures taken in your country been improved because of World No-Tobacco Day? Has public knowledge regarding the harmfulness of tobacco been improved on this occasion? Has the social acceptability of tobacco decreased because of World No-Tobacco Day? Has the general attitude of the public regarding tobacco regulations been affected by World No-Tobacco Day?

The evaluation of World No-Tobacco Day is very important as it serves as a means of confirming the impact of the Day in contributing to a tobacco-free society, but equally important, it enables us to benefit from experience and improve the quality of our anti-tobacco endeavours in the years to come. ▮

The Tobacco or Health programme acknowledges the contributions of Professor Schioldborg and Mr G. Dessart to this section.

FUTURE WORLD NO-TOBACCO DAYS

WHO sees future World No-Tobacco Days as opportunities, not only to ask people to stop smoking for one day, but also to initiate research on specific themes, publish information, and initiate action. Just a quick glance at the list of themes for future World No-Tobacco Days shows what course of action will be pursued.

If you have enjoyed reading this information for World No-Tobacco Day 1993: "Health services: our window to a tobacco-free world", perhaps you can help us prepare future editions of the advisory kit by sending material which could be the basis of our text. Here are the themes for the next World No-Tobacco Days.

1994: "The media against tobacco"
1995: "The economics of tobacco control"
1996: "Sports and the arts without tobacco"
1997: "The United Nations and specialized agencies against tobacco". ▮

Let's make the preparation for World No-Tobacco Day a global endeavour!

Who to contact in WHO

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We inform you, please inform us!

To improve the quality of the information material provided by WHO for future World No-Tobacco Days, we need your feedback, which we are deligted to report is increasing each year. It would thus be much appreciated if you could forward to the WHO Tobacco or Health programme, after the celebration of the Day, a short description of the activities which had been organized in your country or region to mark the sixth World No-Tobacco Day. This description could be substantiated by pictures, posters and newspaper articles or any other material used. Some ideas for this evaluation are given on pages 21 and 22. In addition, we will be glad to receive any official evaluation of the relevance and effectiveness of the information material forwarded by WHO for the occasion and the advice given through this advisory kit and the regional offices or the WHO representatives. ∎

TOBACCO OR HEALTH PROGRAMME

Selected list of WHO publications on tobacco or health

CONTROLLING THE SMOKING EPIDEMIC.

- Report of the WHO Expert Committee on Smoking Control. Technical Report Series 636. World Health Organization, Geneva 1979. Available in English, French, Spanish and Russian.

SMOKING CONTROL STRATEGIES IN DEVELOPING COUNTRIES.

- Report of a WHO Expert Committee. Technical Report Series 695. World Health Organization, Geneva 1983. Available in English, French and Spanish.

SMOKELESS TOBACCO CONTROL.

- Report of a WHO Study Group. Technical Report Series 773. World Health Organization, Geneva 1988. Available in English, French, Spanish and Russian.

WOMEN AND TOBACCO.

- World Health Organization, Geneva. April 1992. Available in English and French.

LEGISLATIVE ACTION TO COMBAT THE WORLD TOBACCO EPIDEMIC.

- Second edition. Ruth Roemer. World Health Organization, Geneva. To be published ultimo 1992. Will be available in English and French.

SMOKE FREE EUROPE.

- A series of 10 booklets published 1988-91 covering all tobacco control elements. WHO Regional Office for Europe. Available in English, French, German and Russian.

IT CAN BE DONE: A SMOKE-FREE EUROPE. REPORT OF THE FIRST EUROPEAN CONFERENCE ON TOBACCO POLICY. MADRID, 7-11 NOVEMBER 1988.

- WHO Regional Office for Europe, 1990. Available in English.

TOBACCO HABITS OTHER THAN SMOKING: BETEL-QUID AND ARECA-NUT CHEWING: AND SOME RELATED NITROSAMINES.

- IARC Monographs on the evaluation of the carcinogenic risk of chemicals to humans. Volume 38. International Agency for Research on Cancer, World Health Organization, Lyon, 1985. Available in English only.

TOBACCO SMOKING.

- IARC Monographs on the evaluation of the carcinogenic risk of chemicals to humans. Volume 38. International Agency for Research on Cancer, World Health Organization, Lyon, 1986. Available in English.

TOBACCO USE: A MAJOR INTERNATIONAL HEALTH HAZARD.

- Proceedings of an International Meeting. D.G. Zaridze and R. Peto (editors). IARC Scientific Publications No. 74. International Agency for Research on Cancer, World Health Organization, Lyon, 1986. Available in English.

OVERALL EVALUATIONS OF CARCINOGENITY. AN UPDATING OF IARC MONOGRAPHS.

- IARC Monographs on the Evaluation of the carcinogenic risk of chemicals to humans. Volumes No. 1-42. Supplement 7. International Agency for Research on Cancer, World Health Organization, Lyon, 1987. Available in English.

ENVIRONMENTAL CARCINOGENS. METHODS OF ANALYSIS AND EXPOSURE MEASUREMENT. VOLUME 9 - PASSIVE SMOKING.

- I.K. O'Neill, K.D. Brunnemannn, B. Dodet and D. Hoffmann (editors). International Agency for Research on Cancer, World Health Organization, Lyon, 1987. Available in English.